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Commitments for "Every Woman, Every Child": a Human Resources for Health perspective

"The only route to achieve the health MDGs is through the health worker: there are no shortcuts".
Chen, L et al (2004)

There are 74 country commitments to the EWEC campaign, containing 484 individual action statements

354 of the action statements address key issues affecting women's and children's health

94% of these either target human resources for health or are dependent on the availability, accessibility, acceptability and quality of the health workforce to achieve them.

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This technical brief provides new analysis of the Every Woman Every Child commitments from a Human Resources for Health perspective. It is made available in support of *World Health Worker Week* (8–12 April, 2013), an initiative launched by the *Health Workers Count* campaign.[1]

INTRODUCTION: There are now less than 1,000 days until the target deadline to achieve the Millennium Development Goals (MDGs). This milestone passed on April 5th 2013 with extensive press and social media coverage highlighting the need for a final push on *"#MDGMomentum"*.[2] Of the eight MDGs, the reductions in maternal mortality (MDG5) and under-five mortality (MDG4) are the two furthest from being achieved.[3]

Global commitment to accelerating progress on MDGs 4 and 5 is most evident within the UN Secretary-General's *Global Strategy for Women's and Children's Health*, launched in September 2010.[4] The Global Strategy, carried forward by the *Every Woman Every Child* (EWEC) campaign, has mobilized more than 250 national and international commitments from different stakeholders, including governments, philanthropic institutions, UN agencies, civil society, private sector and academia.[5] The Global Strategy has also led to the establishment of and recommendations from a Commission on Information and Accountability (CoIA)[6] and a Commission on Life-Saving Commodities (CoLSC).[7] An independent Expert Review Group has also been formed to provide oversight on implementation of the CoIA recommendations.[8] The *Partnership for Maternal, Newborn & Child Health* (PMNCH) provides support to the EWEC campaign to review progress on stakeholder commitments, publishing reports in both 2011[9] and 2012.[10] An update is in preparation for launch in September 2013 in conjunction with the UN General Assembly meeting.

The 2011 and 2012 reports highlighted that the majority of the commitments to the Global Strategy were focused on Human Resources for Health (HRH). In the 2011 report, half of all commitments were on HRH, including one in three on skilled birth attendants and one in four on midwives. Similarly, in the 2012 report: HRH represents 89% of government commitments and 44% of others. Yet the 2012 report notes that "while there is evidence that implementation of commitments is well under way, stakeholders also identified substantial constraints"; in particular, the shortage of skilled health workers is a "critical barrier to implementation". With less than 1000 days to achieve the MDGs, focused attention on addressing the known barriers and challenges to reducing maternal and under-five mortality must be given priority.

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METHODS: We reviewed all global commitments posted on the EWEC website.[5] These include all commitments prior to September 2012, including those made in conjunction with the launch of *Born too Soon: The Global Action Report on Preterm Birth* in May 2012[11], the *Child Survival Call to Action* in June 2012[12] and the *Summit on Family Planning* in July 2012.[13] A total of 275 partner commitments are listed. Each commitment is tagged to enable searches by different criteria (partner, sector of partner, geographical region, issue area of commitment, and year).

To support the HRH analysis we elected to focus only on government commitments. The rationale is that all other commitments would be supportive of country priorities in keeping with aid alignment principles.[14] Each government commitment was reviewed to identify the individual action statements within it and whether these statements could be categorised. The example of Afghanistan's commitment to the Global Strategy (as the first commitment listed in A-Z order on the website[5]) with the 'tags' included by the EWEC website is provided below. We include (in italic numbering) the 8 distinct elements that can be qualified as actions.

FIGURE 1: Commitment of Afghanistan to the Global Strategy

Afghanistan will *(1)* increase public spending on health from $10.92 to at least $15 per capita by 2020. Afghanistan will *(2)* increase the proportion of deliveries assisted by a skilled professional from 24% to 75% through strategies such as *(3)* increasing the number of midwives from 2400 to 4556 and *(4)* increasing the proportion of women with access to emergency obstetric care to 80%. Afghanistan will also *(5)* improve access to health services - strengthening outreach, home visits, mobile health teams, and local health facilities. Afghanistan will *(6)* increase the use of contraception from 15% to 60%, *(7)* the coverage of childhood immunization programs to 95%, and *(8)* universalize Integrated Management of Childhood Illness.

EWEC TAGS: "non-communicable diseases", "reproductive health"

In order to determine the characteristics of each action statement we categorised each by: 1) its EWEC "issue area", 2) IPOOI (Inputs, Processes, Outputs, Outcome, and Impact), and 3) HRH.

1. "Issue area". Each action statement was categorised by the EWEC tagging. This includes HIV/AIDS; Non-communicable diseases; Nutrition; Pre-term Birth; Reproductive Health; and Youth/Adolescents. We found these tags incomplete to describe the actions. We therefore expanded "Pre-term Birth" to incorporate all "Perinatal Care" and added three categories: Funding; Infrastructure; and Policy & Planning.
2. "IPOOI". We further analysed the action statements using the WHO results framework on strengthening monitoring, evaluation and review of national health plans and strategies.[15] This identifies five categories: Inputs, Processes, Outputs, Outcome, and Impact, and outlines indicators for monitoring health sector progress and performance.
3. "HRH". Finally, we assessed whether the action statement was specific to HRH ("direct") or whether its successful implementation was dependent upon HRH ("enabled").

The categorisation was conducted through an iterative process resolving queries as they arose. The IPOOI categorisation proved the more complex; in those instances where an action could be considered either/or we defaulted to the higher category (i.e. if output or outcome, we selected outcome). We excluded those action statements that were categorized as "Funding" or "Infrastructure" in the categorization by HRH.

FINDINGS: The process of deconstructing the country commitments resulted in a total of 484 action statements made by 74 countries.

"Issue area": Of these, 221 (46%) relate to funding, infrastructure or policy and planning. The remaining 263 statements are within thematic health areas, with an emphasis (67%) on reproductive health and perinatal care. Low-income countries have a total of 430 commitments (89%) of which 188 (44%) relate to financing, infrastructure or policy and planning. The emphasis on reproductive health and perinatal care remains high at 67% of all thematic health areas, reflecting priority on MDGs 4 and 5. The majority of high-income country commitments reflect their roles as bilateral development agencies, with 66% of actions targeted at financial support.

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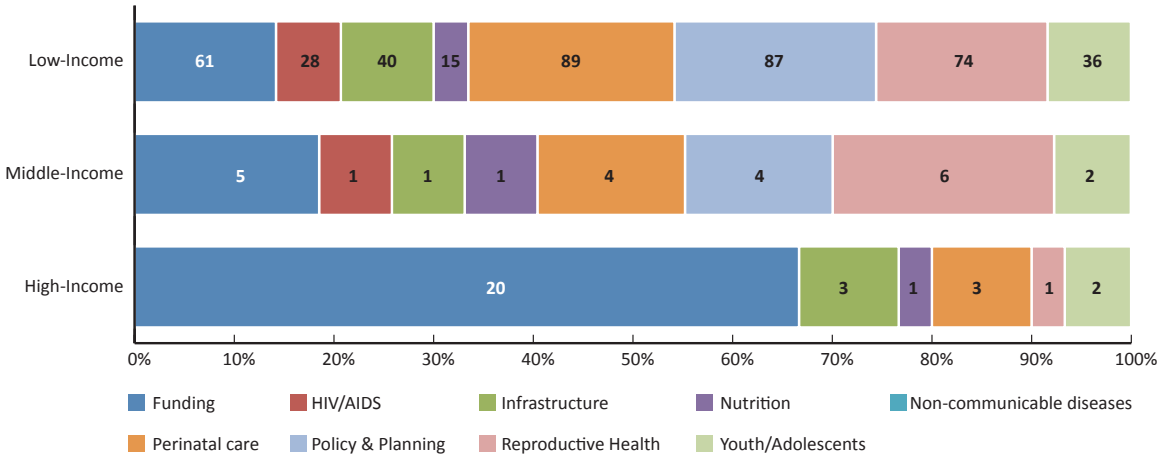
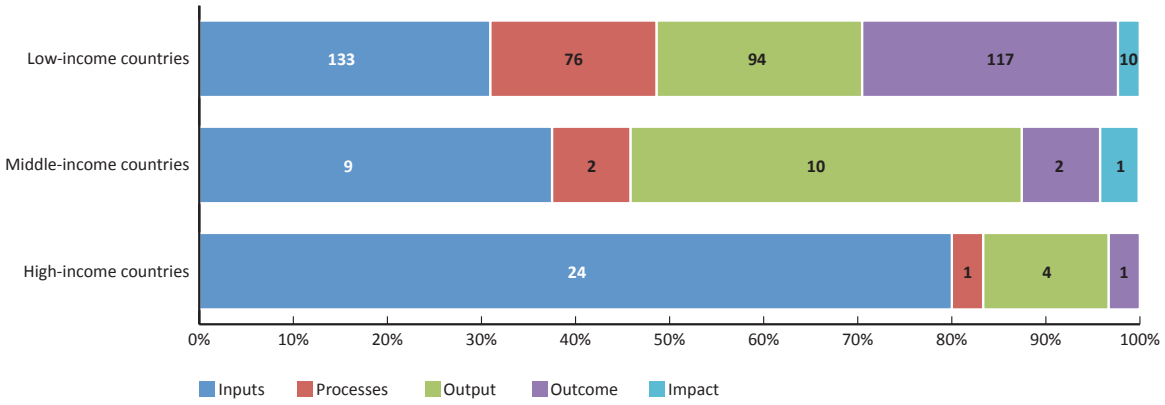
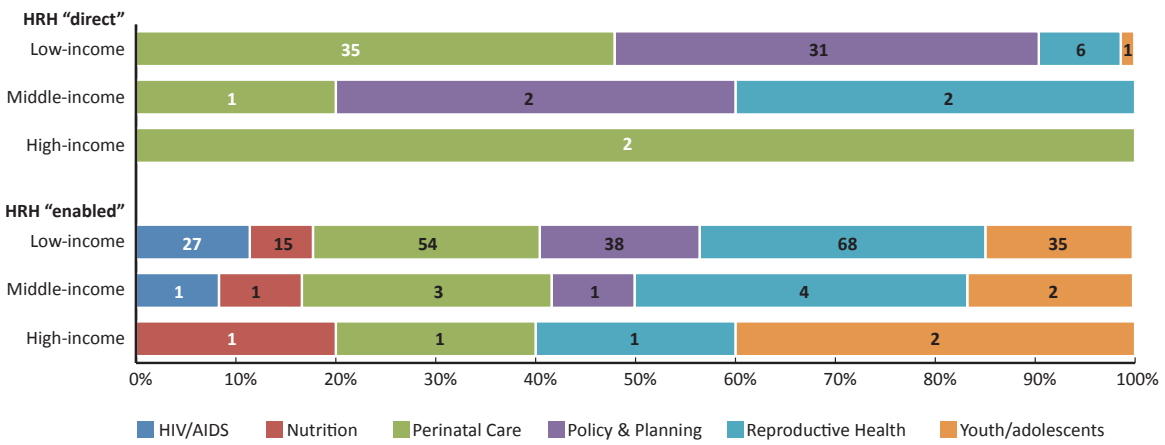


"IPOOI": As anticipated, individual action statements from high-income countries again reflect their roles as providing support through official development assistance. 80% of their commitments are Inputs (mainly financial contributions). Low- and middle-income countries demonstrate a wider breadth of commitments across the IPOOI categories, but there remains a tendency to address supply characteristics in Inputs and Processes (approximately 50%), reflecting the continuing capacity deficits to provide essential health services and expand coverage that will subsequently impact on MDGs 4 and 5.



"HRH": After deducting the 130 funding and infrastructure statements we categorised the remaining 354 action statements by HRH. Of these, 80 commitments (23%) from 47 different countries specify strengthening the health workforce, including additional numbers, education, training and deployment. 73 (91%) of the 80 commitments are from low-income countries, emphasizing their priority to strengthen the Inputs and Processes of their health systems to expand services and coverage. In addition, 65 countries account for 254 action statements that are "enabled" by, or dependent upon access to a skilled, motivated and supported health workforce to achieve them. In combination, 94% of the commitments addressing key women's and children's health issues either target HRH or are dependent on the availability, accessibility, acceptability and quality (AAAQ) of the health workforce to achieve them.



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DISCUSSION: The findings from this HRH analysis complement the exercises conducted by PMNCH in 2011 and 2012, demonstrating the emphasis on Human Resources for Health, but with additional specificity as a result of deconstructing the commitments into their individual action statements. Low-income countries, many of which are challenged to accelerate progress in the next 1000 days to move closer to the MDG targets, identify the necessity to strengthen the AAAQ of their health workforce in order to improve the coverage, quality and impact of health services.

The majority of the individual action statements are dependent on a health worker if they are to be achieved. Yet the 2012 progress report clearly identifies current limitations in the capacity and competencies of the health workforce as a barrier to promoting effective coverage of women's and children's health services. Without due attention and action on the HRH situation within countries, there will be insufficient progress in meeting the MDGs, let alone responding to the call to accelerate the attainment of Universal Health Coverage in the post-2015 development agenda.

Surprisingly, the EWEC campaign has yet to grasp the centrality of the HRH workforce in accelerating progress. Commissions have been formed on information and accountability and life-saving commodities, raising global awareness of these core components of the Global Strategy. Meanwhile, the priorities of low-income countries to address the service providers themselves – the essential health workers who save the lives of women and children through their daily actions – have not been afforded the same international attention. WHO's Director-General has noted that the health worker is the key to achievement of the MDGs. The Executive Board of the World Health Assembly, in its January 2013 meeting, has recognized the need for international solidarity and collective action on the health workforce. The UN Secretary-General has called for "bold steps" on the midwifery workforce to accelerate progress on maternal and newborn health (and by default address the large percentage of under-five deaths that occur in the first few weeks of life). Now, more than ever, with less than 1000 days to go for the MDG deadline, there needs to be an even bigger push to turn evidence and statements into action. Health workers count!

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